Healthpoint

Information from the Division of Health Care Finance and Policy

Division of Health Care
Finance and Policy

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The Division of Health Care Finance and Policy.

On July 1, 1996, the Massachusetts Rate Setting Commission and the Department of Medical Security were consolidated to create the Division of Health Care Finance and Policy. Barbara Erban Weinstein is Commissioner of the new Division. The Division is responsible for the information, pricing, and regulatory functions formerly handled by the Rate Setting Commission. In addition, the Division administers the Uncompensated Care Pool, a fund that reimburses Massachusetts acute care hospitals and community health centers for services provided to uninsured or under–insured individuals.

THE UNCOMPENSATED CARE POOL

The Uncompensated Care Pool reimburses acute care hospitals and community health centers for free care they provide and is a critical link in the state's effort to ensure access to health care to the low-income uninsured and underinsured. Currently, there are a number of proposals to expand health care access to a wider range of people while simultaneously relieving hospitals' responsibility for paying the Pool. This issue of *Healthpoint* looks at the history of the Uncompensated Care Pool and some current policy issues surrounding the Pool's funding and policy goals.

Origin and History

In 1985, the Massachusetts Legislature created a funding mechanism to cover bad debt and free care costs in acute care hospitals and their affiliated community health centers. The Uncompensated Care Pool was established to distribute equitably the financial burden of uncompensated care, to reduce cost shifting, and to eliminate disincentives a hospital might have to providing uncompensated care.

Funding for the Pool came from a uniform surcharge on hospitals' private payer charges. Hospitals were required to reimburse the Pool if revenue they received from the surcharge exceeded their uncompensated care costs. If the surcharge failed to cover a hospital's total uncompensated costs, the Pool would reimburse the hospital for those additional costs. Hospitals passed the surcharge on to private payers, who would incorporate the charge into their premiums.

The Pool Gets a Cap

While maintaining many of the essential components of the Pool, comprehensive health care legislation in 1988 (Chapter 23) contained an important change. The legislature capped the private sector liability for the Pool at $325 million in FY 1988 and reduced it periodically through FY 1992. The legislature has since set the private sector liability at the $315 million for Fiscal Years 1993-1996. The business community hoped that the cap on its liability would protect it from the increasing surcharges it had been paying since the Pool's creation—up to almost 13.1% of charges in FY 1987—while maintaining the integrity of the Pools funding. Since the advent of the cap, the surcharge has gradually decreased to approximately 6% as of FY 1996.

Focus on the Low-Income Uninsured

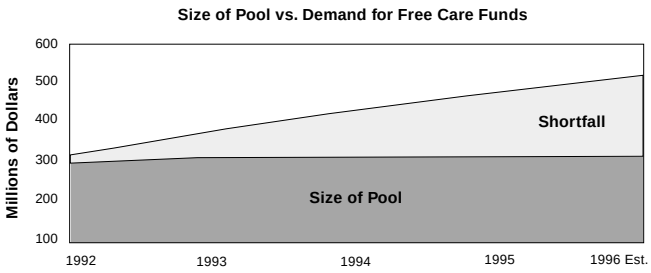
Chapter 495 of the Acts of 1991 retained the private sector cap on the Pool. A significant new provision stipulated that only bad debts generated from emergency services provided to uninsured patients would qualify for reimbursement. Losses associated with all other bad debts (as distinct from "free care" provided to uninsured people meeting low income criteria) would be absorbed by the hospitals that incurred them.

This provision created a stronger incentive for hospitals to collect bad debt instead of writing them off to the Pool.

Current Funding, Allocation and Shortfall

Over the past three years, the Legislature has capped the Pool at $315 million. In addition, the budget has provided to the Pool $15 million from the general fund, financed by federal matching funds. Almost since in inception, the demand for uncompensated care reimbursement has grown while Pool funding has remained relatively constant resulting in a shortfall.

The current method for Pool reimbursement and shortfall allocation reflects a desire to distribute the financial burden of free care in a way that does not competitively disadvantage hospitals providing a large amount of free care.



Chapter 495 instituted this "Greater Proportional Requirement" method which stated that "hospitals with the greatest proportional requirement for Pool income shall receive a greater proportional payment from the Pool."

The Pool methodology assesses each hospital a contribution equal to approximately six percent of private pay charges. The Pool then reimburses a hospital for its free care costs, less the hospital's share of the shortfall, which is uniformly distributed based on size; larger hospitals are responsible for a greater share of the shortfall than smaller facilities. The net result is that a hospital's proportional reimbursement of its free care costs grows with the amount of free care it provides.

The chart on page 3 illustrates this method by showing two hospitals of equal size providing different levels of free care, therefore receiving different levels of reimbursement from the Pool. Both facilities, however, are responsible for the same amount of the shortfall.

The Future of the Pool

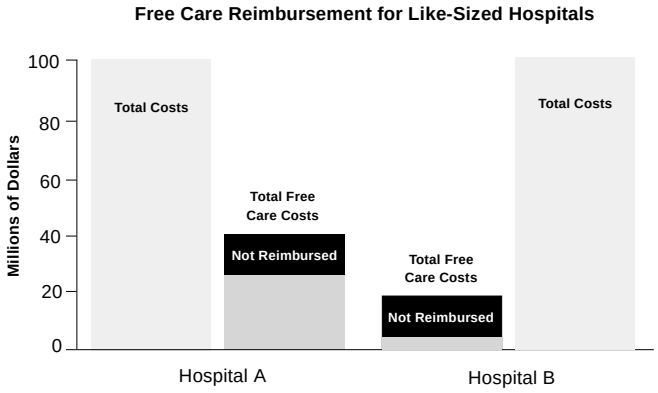
As the dynamics of the health care industry have changed, there has been a corresponding effect on the funding of the Pool. Prior to creation of the Pool, each hospital was responsible for recouping the costs of its own free care and bad debt. The original Pool sought to distribute this burden more equitably.

Chapter 23 brought the cap on private sector liability to the Pool, limiting hospitals' ability to pass uncompensated care costs along to private insurers. The risk for costs exceeding the cap fell to hospitals and, to a small degree, to the Commonwealth.

The competitive market ushered in by Chapter 495 has made more complex the questions of Pool funding. Private sector liability to the Pool remains capped, and many payers now negotiate payment arrangements with hospitals that are not bases on their charges. Hospitals contend that, in this environment, they are less able to collect the surcharge from insurers and are forced to absorb this loss. Insurers argue that their contributions to the Pool are incorporated in the rates they pay to the hospital. With increasing movement toward managed care and innovative payment arrangements, the issue of how the Pool is and should be funded is of increasing concern to the Governor, legislature and all interested parties. A recently enacted law establishes a special commission to recommend a long-term plan to reform the structure of the Uncompensated Care Pool. The special commission will file its plan with the legislature by the end of 1996, and will likely address some or all of the following issues.

Funding Mechanism

Initiatives have been proposed to broaden the Pool's base by expanding the groups paying directly to the Pool. One version would assess commercial insurers, including health maintenance organizations, an annual liability to the Pool. The aggregate liability of acute care hospitals would correspondingly be reduced. A variation of this approach would also prohibit insurers from raising premium to consumers and from reducing payments to hospitals. The insurance industry argues that they would be required to pay the assessment without the ability to raise the necessary revenues. The business community fears insurers would find ways to pass the costs along to employers.



Should the special commission recommend a new funding mechanism for the Pool, the Employee Retirement Income and Security Act (ERISA) of 1974 must be considered. The federal law preempts state employer health coverage mandates and protects self-funded health plans from state "taxes." When health plans in New York used ERISA to challenge a state law requiring hospitals to collect surcharges from them, the U.S. Supreme Court ruled that the economic impact of the surcharge on ERISA plans was indirect and "not substantial enough to trigger preemption." Proposals to broaden the Pool's base should consider such relevant case law.

The commission must also consider that the Commonwealth currently receives $120 million per year in federal matching funds on Uncompensated Care Pool expenditures. To continue to be eligible for these funds, the state must assure the Health Care Financing Administration (HCFA) that its financing methodology satisfies HCFA's rules.

Responsibility for Financing Uncompensated Care

A central issue is how should the financial burden of the costs of uncompensated care be distributed? Hospitals believe they shoulder this responsibility because they actually remit the Pool dollars to the state. Hospitals also contend that when there is a Pool shortfall, it is they who provide the care that may not be reimbursed. Private insurers, by virtue of the fact that they write the check to the

hospital for their enrollee's hospital bill, believe they share in this responsibility as well. Employers and employees may also bear some of the burden through premiums, co-pays and deductibles.

Access for the Uninsured

Opinions differ whether the Pool's purpose is to assist hospitals in financing the care they provide to the uninsured, or to assist low-income citizens to secure adequate health care coverage; policy proposals reflect this debate. Efforts to decrease use of Pool funds by expanding the insured population began under Chapter 23 and continue to the present. Recent legislation has been enacted to increase health coverage for children and the elderly, and to expand Medicaid eligibility. These programs, coupled with existing programs for uninsured individuals at community health centers and medical respite services under Boston's Health Care for the Homeless program, have increased the number of insured citizens in the Commonwealth.

Some argue these programs are incomplete, "band-aid" approaches and that it is the state's responsibility to provide health care for its uninsured and underinsured citizens. Others believe that the money used to reimburse hospitals for uncompensated care might be better spent paying monthly premiums for individuals enrolled in a health plan.

Viability and Longevity of the Pool

Determining the future of funding for uncompensated care in Massachusetts will require balancing the interests of diverse parties—uninsured individuals, providers, insurers, employers, state and federal governments, to name but a few. This is a complicated proposition, made more so by the reality that issues of uncompensated care are intertwined with broader issues of the entire health care system. The membership of the special commission that will consider uncompensated care funding reforms this fall represent a range of opinions; its challenge will be to incorporate those views into a workable consensus.

Did you know?

Hospital Facts

	Massachusetts		Massachusetts			U.S.	California
	FY96 Data Submitted to Date	Comparable FY95 Data	FY95	FY94	FY90	FY94	FY94
Number of Hospitals							
Acute	79	83	83	87	92	5,229	427
Non-Acute	56	56	56	54	65	811	60
Number of Acute Hospital Discharges (thousands)	364	387	783	823	895	30,718	3,021
Number of Acute Hospital Discharges/1,000 population	***	***	131	137	153	118	94
Number of Acute Hospital Days/1,000 population	***	***	705	766	1,046	796	529
Acute Hospital Length of Stay	5.29	5.47	5.35	5.68	6.82	6.70	5.60
Percent Inpatient Hospital Revenues	N/A	N/A	60%	64%	72%	72%	75%
Percent Outpatient Hospital Revenues	N/A	N/A	40%	36%	28%	28%	25%

	Massachusetts Medians					
	FY95	FY94	FY93	FY92	FY91	FY90
Total Revenue ($millions)	73.92	72.46	63.44	57.97	54.10	48.58
Total Expenses ($ millions)	71.31	70.43	62.51	56.95	53.40	48.26
Net Income ($ millions)	1.96	1.10	2.17	1.76	1.09	1.13
Fund Balance ($ millions)	24.29	22.56	18.80	15.47	13.57	13.50
Total Margin	3%	2%	3%	3%	2%	2%

Sources: Division of Health Care Finance and Policy; *Hospital Statistics - 1994/95* (American Hospital Association); *Massachusetts Medians* - Division of Health Care Finance and Policy (preliminary data)

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